
The advertising of doctors' services

D H Irvine *General Medical Council*

Author's abstract

Medicine is unique among professions and trades, offering a 'product' which is unlike any other. The consequences for patients of being attracted by misleading information to an inappropriate doctor or service are such as to demand special restrictions on the advertising of doctors' services. Furthermore, health care in the UK is organised around the 'referral system', whereby general practitioners refer patients to specialists when necessary rather than have specialists accept patients on self-referral. But this need not inhibit the provision of helpful factual information to those who need it. Recent policy changes by the General Medical Council considerably broaden the scope for general practitioners to make factual information of their services available to local people, while safeguarding the public against promotional activities which are designed to increase demand for certain kinds of specialist service by playing upon individuals' fears and lack of medical knowledge.

Revised guidance by the General Medical Council (GMC)

In May, 1990 the GMC approved revised guidance on the advertising of doctors' services in the UK, significantly relaxing its previous policy on the matter. The most obvious of the changes concern the advertising of general practitioner services: general practitioners are now allowed to publish information about their services in newspapers and the other media, and may also distribute such information on an unsolicited basis, for example by means of 'mailshots' or door-to-door leafleting in their areas.

Given the antipathy of the medical profession to competitive activities of a 'commercial' kind and the convention, long regarded as fundamental to medical ethics in this country, that doctors should refrain from self-promotion, this revision of policy may seem to represent something of a sea-change in established attitudes. But the council's standards committee,

having been engaged in reviewing the council's published guidance over a number of years, came to see the proposals it put to the council as further steps in a logical process in which an even more significant policy change had already been accepted, four years previously.

The role of the General Medical Council

The GMC, which was established in 1858, has the role of protecting the public by regulating the activities of the medical profession. It keeps a register of qualified doctors, promotes high standards of medical education, co-ordinates the various stages of medical education and is responsible for professional discipline and fitness to practise. Its functions are governed by law, currently the Medical Act 1983, section 35 of which requires it to provide, 'in such manner as it thinks fit', advice for doctors on standards of professional conduct or on medical ethics. It does this through the issue of general guidance for the medical profession as a whole and by giving advice, on request, to individual doctors.

The original Warning Notice

The view that any but the simplest forms of information-giving by doctors were improper was so widely held within the profession, and regarded as so self-evident, that the GMC did not consider it necessary to issue advice on the subject until May, 1894 when, having received a petition from 130 registered dentists (over whom the GMC also had jurisdiction at that time) about the advertising practices of 21 specified dentists, it resolved: 'That the issue of advertisements of an objectionable character, and especially of such as contain either claims of superiority over other practitioners, or depreciation of them, may easily be carried so far as to constitute infamous or disgraceful conduct in a professional respect' (1).

In May, 1905 the British Medical Association asked the GMC 'to consider the desirability of issuing a general warning notice to medical practitioners against the practices of canvassing and advertising for the purpose of procuring patients'. Having considered the matter, the GMC published a notice containing a

Key words

Advertising; competition; self-regulation; patient choice; referral system.

solemn warning:

'... some registered medical practitioners have, with a view to their own gain and to the detriment of other practitioners, been in the habit of issuing or sanctioning the issue of advertisements of an objectionable character, or of employing or sanctioning the employment of agents or canvassers, for the purpose of procuring persons to become their patients ... in the opinion of the council such practices are contrary to the public interest and discreditable to the profession of medicine: the council hereby give notice that any registered medical practitioner resorting to such practices thereby renders himself liable to be charged ... with "infamous conduct in a professional respect", and ... the council may, if they see fit, direct his name to be erased from the Medical Register' (2).

It appears that throughout this period the council was in some respects prepared to accept a different standard of conduct on the part of dentists, and as late as 1914 the council's solicitor stated without dissent on the part of the council that 'advertising is forbidden altogether to medical practitioners, but not altogether to dentists'. Nevertheless, the above text was incorporated into a consolidated Warning Notice published in 1915 and, although its precise terms were developed and expanded on a number of occasions between then and 1986, in response to new situations and changing circumstances, the substance of the guidance remained much the same.

Essentially, advertising which sought to obtain patients for particular doctors, or to promote doctors' professional advantage, or to suggest that they possessed qualities not possessed by other registered medical practitioners, continued to be regarded as improper, both on the ground that unscrupulous advertising by doctors could be a source of danger to the public and by virtue of the principles which, it was argued at the time, should govern relationships between members of a profession.

During the early 1980s signs began to appear that the long-established policy described above was no longer comprehensible to the public, nor did it command universal support among doctors. An imaginative paper by the Patients Liaison Group of the Royal College of General Practitioners was published in the college's journal in December, 1984 (3), arguing for better information in the local medical lists prepared by the primary care authorities and improvements in the leaflets which general practitioners themselves produced for their patients. At the same time another interesting initiative was under way, in a project undertaken by the Scottish Consumer Council to produce a directory of GP services in part of North Edinburgh. The resulting, purely factual publication was informative, attractive and readily understood, and served to illustrate the advantages for patients of having available a comparative directory of local services.

Review by the standards committee

In February, 1985 the council's standards committee decided to review the guidance from first principles. The guidance at that time (4) was still cast in the form of a series of warnings against behaviour that might amount to a professional disciplinary offence, and the committee recognised at once that its tone and content no longer accurately reflected either the realities of modern medical practice or the climate of public opinion in which doctors were now providing their services.

Consultation with professional bodies and bodies representing patients disclosed needs in three particular areas:

- by the public for accurate and accessible information about the range of general practitioner services in each area;
- by general practitioners for information about the specialist services available in their locality for referral of patients;
- by both public and profession for wider provision of information about doctors' qualifications and training, particularly in specialist fields.

It rapidly became apparent, however, that no patient or consumer organisation favoured promotional advertising by doctors, or indeed any measure whose prime purpose would be to increase competition among them. It is my impression that that remains the case.

Looking back at the discussions that took place during that review, it is interesting to see how the issues that seemed so significant at the time, and which raised temperatures both within and outside the profession, now seem strangely insubstantial. Initially, for example, there was less enthusiasm in the profession than among patients' organisations for widespread dissemination of information about doctors' qualifications and training, in the belief that the public would not understand the significance of such information. The council did not accept that argument and explicitly recognised the need for patients to have better information about doctors' qualifications.

There was also considerable opposition from some bodies representing doctors to the idea that general practitioners should be allowed to provide information not only to their existing patients but to people inquiring about the practice and the services available. It was argued that this would lead to the 'poaching' of patients from one practice to another, would allow unscrupulous doctors to put pressure on patients to register with them and, generally, would promote an indecent amount of competition between doctors to the detriment of the profession's reputation. But the council recognised the strength of the argument that patients needed information about general

practitioners **before** they made a choice of practice, and that to deny them access to such information not only impeded choice but paid scant regard to the autonomy of the individual and the capacity of patients to make rational decisions.

The result of the review was the publication in 1986 of revised guidance to doctors which markedly lessened the previous restrictions on the provision of information in order to meet the needs identified above. In a number of respects the GMC went further than some professional bodies would have wished, and indeed that is a proper role for the council: to lead the profession rather than simply to reflect established opinion.

It was at this time that the council signalled its acceptance of what has been, in our opinion, the most fundamental of the changes which have been made to its policy on advertising in recent years. Recognising that the **distribution** of information material about general practitioners and their services was becoming increasingly difficult to control, and that in any case it was far more important, and worthwhile, to control the **content** of that material, the council decided to allow general practitioners to give information about their practices to inquirers who were not already patients, and also to place it in local libraries and other information centres such as town halls, police stations, Citizens' Advice Bureaux and similar places. It was not the council's intention at that stage to allow the wider dissemination of information material, for example by the placing of notices in newspapers, or by unsolicited distribution throughout a local area. Nevertheless, once the principle had been established that information about general practitioners and their services could be made available to people other than existing patients, the way was open – at least in logic – for further relaxation of the guidance in order to allow even wider distribution.

Generally, the council regarded the 1986 revision as representing a change in the **tone** of the guidance as much as providing the opportunity to clear up anomalies, clarify points of principle and recognise changes in the climate of public opinion and the attitude of a growing number of general practitioners. Perhaps the most important demonstration of this change was to be seen in the introductory paragraphs, where a series of straight warnings gave way to a discussion of the need to foster and maintain good communication between doctors and patients, and between one doctor and another, as an essential element of effective patient care. Although the guidance still referred to conduct by doctors which might be 'incompatible with the principles which govern relationships between members of a profession' (5), matters of professional etiquette and the discouragement of competitive activities received far less attention than the need to ensure that the public was not endangered by misleading advertising.

Action by the Government

Shortly after the 1986 guidance was issued the Office of Fair Trading (OFT) began to show an interest in the restrictions on advertising by doctors. The OFT is a Government agency which is responsible for identifying unfair or anti-competitive trading practices. After some preliminary inquiries the Monopolies and Mergers Commission (MMC) was directed to investigate the position. The MMC had previously reported on advertising restrictions in several other professions, and this new reference was evidently the latest in a series intended to bring the principles of the free market to bear on professional services as well as on commercial services and trades. The GMC was asked to explain and defend its guidance on the subject. The MMC took evidence from a variety of bodies and individuals representing both the profession and the public and published its recommendations in March, 1989 (6). For the standards committee the process of giving evidence to the MMC, responding to its recommendations and then revising its guidance to the profession has constituted a process of almost continuous review which has accorded the subject of advertising a scrutiny more detailed, and more wide-ranging, than any other ethical subject in the recent history of the committee.

Return to first principles

The implicit challenge, not only to the council's guidance on one specific area of practice but to the whole principle of the profession's right to regulate its own activities, led the standards committee once again to return to first principles. Would the argument stand up to scrutiny that medical services are different in kind from other services purchased by individuals, and that their advertisement should therefore be subject to greater restrictions? Could distinctions still reasonably be made between factual and promotional information, between informing individuals and putting pressure on them, and between the advertising of general practitioner services and that of specialist services? Were the medical profession entitled to make assumptions about patients' need for information about doctors' services and their capacity to understand that information if they received it? And were patients more in need of protection from misleading advertisements at some times than at others? Broadening the debate somewhat, could the 'referral system' still be defended as in the interests of patients, or was it just another restrictive practice which reinforced the mystique of a profession and hampered consumers from gaining access to the services they required?

A question of terminology

Superficially, a certain amount of the debate has always turned on what exactly is meant by the term 'advertising'. To some, the word implies no more than

the provision of information about a service, for the benefit of potential consumers. To others, it implies the whole range of promotional techniques – both hard-sell and soft-sell – which are designed to gain the largest possible market share for an individual or firm; such activities might include not only published or broadcast advertising but also unsolicited visits or telephone calls to targeted individuals. Putting aside the individual perceptions and received ideas which each of us has about what the word 'advertising' may mean, the standards committee has tried throughout to regard it as a neutral term: in the provision of information about doctors' services there is both desirable and undesirable advertising. Our discussions with the OFT and the MMC, and indeed within the council itself, were focused essentially on the question of where the line between the two should be drawn.

Why medical services are different from other services

The right of a profession to regulate itself depends on its retaining the public's confidence that it will put the public interest above the interests of its members. But every profession is unique, with its own responsibilities, privileges and traditions, and each has its own perspective of how its members should conduct themselves. Professional self-regulation is easily misrepresented as self-interest. The standards committee therefore thought very carefully before advancing the argument that the provision of medical care is different in kind from the provision of other services. It was only too apparent that to a body such as the MMC, whose members are drawn predominantly from the commercial world, medical care could appear to be simply one of many goods and services which consumers are accustomed to buy in the marketplace.

The council did however argue that medicine is different from other professions, on a number of grounds, and indeed the MMC accepted the essence of that argument by agreeing that the advertising of medical services could remain subject to more restrictions than those which they had allowed in other professions. Medical care is not a product which can be assessed and then accepted or rejected before purchase. It cannot later be returned to the shop if found unsatisfactory. People seeking medical advice or treatment cannot usually know what they are getting until after they have obtained and tried it. The consequences of choosing an inappropriate doctor could, in extreme cases, be disastrous, with no second chance to rectify an error. Financial recompense alone cannot restore to a patient health which has been irreparably damaged, nor compensate the bereaved for a life lost. Such immediate and, sometimes, catastrophic consequences are very unlikely to occur when services are sought from, for example, an accountant, a solicitor, an architect or a stockbroker.

The guidance which was scrutinised by the MMC distinguished between 'the ethical dissemination of

relevant factual information' (7) and three areas in which doctors' advertising could overstep the mark into the unethical:

- the use of promotional advertising techniques;
- canvassing, or touting for patients;
- the disparagement of professional colleagues.

The third of those points raises wider issues which have been dealt with separately by the standards committee. The new guidance on advertising warns doctors against disparagement in the context of advertising material (what the MMC calls 'knocking copy'), but the broader question of comment by a doctor upon a professional colleague is another matter. The other two points noted above were however studied intensively by the committee, returning to the earlier debate about whether to control the content of advertising material or to control its distribution.

Can 'factual' and 'promotional' advertising be distinguished?

To maintain a distinction between 'information-giving', on the one hand, and the full panoply of promotional techniques on the other inevitably involves making a subjective judgement as to where one ends and the other begins. Although there has in the past been something of a consensus within the profession on the matter, the diversity and complexity of modern medical practice has made it increasingly difficult to maintain a hard and fast line. In any case, it is readily apparent that even demonstrably factual material can be presented in such a way as to be highly promotional in its effects. Even the simplest statements about doctors and their services will inevitably, because of what they choose to include or omit, enable inferences to be drawn about what is on offer. The standards committee recognised that this was a natural process, and that it was no longer profitable to rely on the word 'promotional' to provide doctors with adequate guidance as to forms of information-giving which were regarded as unacceptable. Here the debates at the time of the 1985/86 review, and particularly the crucial decision to allow the release of GP information outside the existing patients of a practice, were especially helpful: by spelling out more explicitly than before the principles which should underlie the **content** of GP advertising material we now found ourselves able to recommend further substantial relaxation of controls on its **distribution**.

Canvassing and pressure

The other warnings mentioned above concerned activities under the general heading of 'canvassing', a concept which has long been regarded as distasteful in

several professions but which no longer appears, in the same form, in the council's new guidance on advertising. Canvassing was previously held to encompass not only direct approaches to individuals but also the unsolicited distribution of advertising material, including advertising in the press or other media. It was in reconsidering exactly why that kind of activity might be regarded as unethical that the council identified the need to take a further step in relaxing the guidance about the distribution of advertising material. Previously the GMC had sought to allow, for example, general practitioners' practice leaflets to be made available to the public in a range of local places where individuals could expect to find material about all the general practices in their area. The council held at the time that offering patients information about one practice at a time would distort choice, but at the same time we were allowing people to collect practice leaflets from individual surgeries on which they were prepared to call. The MMC rightly pointed out the illogicality of that policy, and further reflection on the matter led to the conclusion that, having already allowed such material to be given to inquirers as well as to a doctor's existing patients, it would not be unreasonable to extend that principle by allowing unsolicited distribution within a general practitioner's area, and indeed to the placing of notices in newspapers and the other media.

Having thereby conferred legitimacy on two forms of activity which had hitherto been proscribed, the committee was left to consider whether any other forms of what had been termed 'canvassing' should still be regarded as unethical. Should consumers not be allowed to make a free choice on the basis of whatever information might come their way, and whatever techniques might be used to attract their attention? We decided that it was when patients, or prospective patients, were **put under pressure** that difficulties would arise, and indeed the MMC endorsed that view. Unsolicited visits or telephone calls (which in marketing terms constitute 'cold calling'), with a view to attracting potential patients, are therefore ruled out.

The distinction between general practitioner services and specialist services

A characteristic of the arrangements for health care in the UK is the system whereby the great majority of patients make their first approach for investigation or treatment to a general practitioner and are then referred on to a specialist if appropriate. The general practitioner provides continuity of care by accepting responsibility for providing general medical services, acting as each patient's first point of contact with the medical profession and keeping a comprehensive record of each patient's health history. Some 99 per cent of the population are registered with a general practitioner and 90 per cent of medical episodes are dealt with outside hospitals, mainly by general practitioners.

This 'referral system' is valued by both patients and doctors. Moreover, it has been upheld by Parliament as a fundamental feature of the National Health Service since its inception. When the MMC began its scrutiny of the council's guidance on advertising we were by no means certain that the outcome would not seriously undermine that system by permitting direct advertising to the public by all doctors, general practitioners and specialists alike. We considered it unrealistic to imagine that such a change would not have that effect. We therefore had to balance the potential advantages for patients of being better informed about the specialist services available to them with the potential consequences of dismantling the present arrangements for medical care in this country.

Further, we also considered the likely consequences for individual patients of the encouragement to self-referral which would inevitably follow from direct advertising by specialists. Attendance upon the wrong kind of specialist, chosen by a patient through lack of expertise, could have serious consequences, primarily medical but also financial, and while it could be argued that advertising to the public by specialists would expand patient choice it would also open the way for exploitation in those areas of practice where the unscrupulous can most easily prey upon the fears of individuals.

It is at this point that the council's line of argument can quite easily be misrepresented as paternalistic: why should individuals not be allowed to make their own choices and look after their own interests? In reply we have consistently argued that individuals, however mature and well-informed, often act differently, and sometimes quite irrationally, when they or one of their family are ill, or where there is the fear of illness. It is at such a time that specialist care is most likely to be needed, and when facing that possibility any of us might be found at our most uncertain and vulnerable. The choice of one or more specialists, to deal with a particular situation, is in that respect quite different from the choice of a general practitioner to provide primary care; patients usually register with a GP when they are well and can be expected to think and act rationally. Considerations of this kind provided the council with its most compelling arguments in putting evidence to the MMC, as described earlier in this article, about why medical services are different in kind from other services. Equally, though, it became clear that the same logic made it impossible to sustain the argument against relaxing the restrictions on advertising by general practitioners. We took the point, and the distinction is now stated clearly in the council's new guidance:

'Most individuals, when choosing a general practitioner, are in good health and able to make a rational choice on the basis of factual information. People requiring the attention of a specialist may, by contrast, be ill or in a vulnerable state and need expert advice before being referred for further investigation

or treatment. Equally, the specialist to whom a patient is referred needs information of the patient's medical history and of any treatment which may already be under way' (8).

Paternalism perhaps, but caring in its intent and emphatically aimed at the protection of patients. The council has however been pursuing separate arrangements under which doctors in all branches of medical practice, who have completed higher specialist or vocational training, can have information of that fact entered in the Medical Register, which is publicly available and is used by all health authorities. Further, during the course of this latest review the council decided to allow individual specialists to provide information about their services to general practitioners, and to other professional colleagues, not just when they set up in practice but as frequently as they wish.

Developments within the National Health Service

This latest review of the council's guidance was conducted against the background of some important changes taking place within the National Health Service. All NHS general practices are now required to produce a practice leaflet, and the authorities responsible for GP services now have to produce local directories which give information about all the general practices in an area, enabling patients to compare what is on offer before making a choice. It remains the council's view that this kind of comparative information (termed 'corporate advertising' by the MMC) is likely, over time, still to provide patients with the best means of choosing a family doctor with whom to register, although the Family Health Service Authorities still have some way to go in improving the presentation of their information material and making it more accessible to patients. Some health authorities are now also improving the material which general practitioners receive about local specialist services within the NHS, although again there is still considerable room for improvement in that area.

Conclusion

To some doctors the recent relaxation of the council's policy towards advertising has been less than welcome. Equally, the changes made in 1986 were greeted with scepticism in some quarters but they have not acted against the interests of patients. I believe that the council's policy as it now stands represents a reasonable development of those earlier changes, and that it shows the regulatory body of the medical profession in the UK able to respond both to changes in the way medicine is practised and to criticism of established attitudes which no longer stand up to detailed scrutiny.

Donald Irvine, CBE MD FRCGP is Chairman of the General Medical Council's Committee on Standards of Professional Conduct and on Medical Ethics. He is a general practitioner in Northumberland and is also currently Chairman of the Joint Committee on Postgraduate Training in General Practice.

References

- (1) General Medical Council. Minutes. Vol XXXI: 105. London, 1985.
- (2) General Medical Council. Minutes. Vol XLII: 138 London, 1905.
- (3) Patients' Liaison Group of the Royal College of General Practitioners. Availability of information for patients. *Journal of the Royal College of General Practitioners* 1984; 34, 269: 672-673. See also page 644.
- (4) General Medical Council. *Professional conduct and discipline: fitness to practise*. London, 1985. Part II, section (iv): 15-16 and part III, section (iv): 23-27.
- (5) General Medical Council. *Professional conduct and discipline: fitness to practise*. London, 1987: 15, para 60.
- (6) Monopolies and Mergers Commission. *Services of medical practitioners: a report on the supply of the services of registered medical practitioners in relation to restrictions on advertising*. London: HMSO, 1989.
- (7) See reference (5): 15, para 59.
- (8) General Medical Council: *Professional conduct and discipline: fitness to practise*. London, 1990: 23, para 92.